



STATE OF HAWAII  
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
HAWAII OCCUPATIONAL SAFETY & HEALTH DIVISION  
Princess Keelikolani Building, 830 Punchbowl Street, Room 321, Honolulu, Hawaii 96813  
PHONE: (808) 586-8146 FAX: (808) 586-9099 EMAIL: HMOAB@hawaii.gov

## HOISTING MACHINE OPERATOR'S APPLICATION FOR CERTIFICATION

**COMPLETE APPLICATION MUST BE TYPED OR CLEARLY PRINTED IN BLACK INK**

TYPE OF APPLICATION: (Check the appropriate box) <input type="checkbox"/> NEW <input type="checkbox"/> RENEWAL <input type="checkbox"/> REVISION OR LOST CARD	CERTIFICATE NUMBER (if known):
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### A. PERSONAL DATA

NAME LAST FIRST MIDDLE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
TITLE OR POSITION		EMPLOYER
BUSINESS ADDRESS NUMBER STREET CITY STATE ZIP		COUNTRY IF NOT IN USA <input type="checkbox"/> SEND MAIL HERE
HOME ADDRESS NUMBER STREET CITY STATE ZIP		<input type="checkbox"/> SEND MAIL HERE
INCLUDE AREA CODE HOME PHONE	HOME EMAIL	INCLUDE AREA CODE BUSINESS PHONE
		INCLUDE AREA CODE BUS. FAX

### B. CERTIFICATION REQUIREMENTS

All documents must be submitted or your application will not be processed.

1. <b>2 Valid Original Government Issued ID's (Birth certificate, Driver's License, Passport or Hawaii state ID):</b> (Please notarize if mailing in)  (1) ID Type _____ Number (if applicable) _____ Expiration Date: _____ (2) ID Type _____ Number (if applicable) _____ Expiration Date: _____ (3) Email current photo to <a href="mailto:HMOAB@hawaii.gov">HMOAB@hawaii.gov</a> (must be jpeg format)
2. <b>Physical Examination</b> must meet the requirements of ASME B30.5 Section 5-3.1.2(a). Submit a complete and current copy of one of the following:  a. _____ A NCCCO Medical Examiner's certificate. Expiration Date: _____ b. _____ A Department of Transportation Medical Examiner's certificate. Expiration Date: _____
3. <b>NCCCO Certificate Number:</b> _____ <b>Expiration Date:</b> _____  Specialties: __STBC/TSS__LTBC/TLL__LBTC/LBT__LBCC/LBC__TWR__SGP__OVR__RIG__
4. <b>Fees: All application/certification fees are nonrefundable. Make checks payable to "Department of Labor."</b>  a. _____ \$50.00 Nonrefundable application fee due at the time of application submittal. (initial applications only) b. _____ \$500.00 Certification fee (prorated if certification period is less than 5 years to \$100 per calendar year) Due within 30 days of application approval. c. _____ \$10.00 for re-issuance of card.  <b>Total Amount Due: \$</b> _____

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## C. CRIMINAL HISTORY (Please check the appropriate boxes)

A criminal history record check will be conducted on all applicants.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been charged with any serious crime or felony? If "yes:"  Were you convicted? If "yes," explain: _____ _____  Date(s) of Conviction(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you a fugitive from justice? If "yes", explain:

## D. PHYSICAL OR MENTAL CONDITIONS (Check the appropriate boxes)

Do you have any physical or mental condition (disease, injury, or illness) which may impair, restrict, or interfere with your ability to operate or supervise the operation of a hoisting machine safely? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
If "yes," please identify each condition, and explain its effects:

## E. SUBSTANCE USE (Check the appropriate boxes)

Do you use any drug or have an alcohol condition that may impair, restrict, or interfere with your ability to operate or supervise the operation of a hoisting machine safely? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Non-prescribed narcotic, drug, or controlled substance?
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or any substance (including prescription drugs) that may impair, restrict, or interfere with your ability to operate or supervise the operation of a hoisting machine safely?
If "yes" to any of the above, explain:		

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## F. HOISTING MACHINE ACCIDENT(S)

All accidents must be reported to the Director of Labor & Industrial Relations within 24 hours.

<b>HAVE YOU BEEN RESPONSIBLE FOR OR CONTRIBUTED TO AN ACCIDENT INVOLVING A HOISTING MACHINE?</b> If "yes," list all accident dates and explain: (Please use additional sheet if necessary)
Date: _____
Date: _____
Date: _____

### CERTIFICATION:

By signing below, I hereby certify that all responses and statements on this application are true and complete to the best of my knowledge and that any misrepresentation or omission may be sufficient grounds for the denial or revocation of a Hoisting Machine Operator's Certificate and punishable under the laws of the State of Hawaii.

I understand that this application is subject to verification, and I agree to provide any additional documentation that may be required.

I agree that outside sources may be contacted to verify the information I have given in this application and hereby consent to the disclosure of any information needed to determine the validity of this application and/or my eligibility for a certificate.

I affirm that the statements given are true under penalty of law.

Signature of Applicant	Print Name	Date
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**Return completed form and check to:**     **State of Hawaii**  
   **Department of Labor and Industrial Relations**  
   **830 Punchbowl Street, Room 321**  
   **Honolulu, HI 96813**

**Make checks payable to "Department of Labor." Send jpeg of applicant's face to [HMOAB@hawaii.gov](mailto:HMOAB@hawaii.gov).**

Date Received:	Approved by:	Date completed/letter sent & issue date:
Check No.:	Check Date:	Check Amount: